ADA 2019 Nutrition Therapy Consensus Report
Application in the Real World Through Participatory Learning: Part 3

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• Notice of Requirements For Successful Completion
  – Please refer to learning goals and objectives
  – Learners must attend the full activity and complete the evaluation in order to claim continuing education credit/hours.
• Conflict of Interest (COI) and Financial Relationship Disclosures:
  – Shamera Robinson, MPH, RDN – Employee of American Diabetes Association
  – Kelly Rawlings, MPH – Employee of Vida Health, Twitter chat presenter on behalf of LifeScan Diabetes Institute
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Objectives

Participants will be able to:
• Discuss key concepts and new evidence from the ADA nutrition consensus statement.
• Discuss practical ways to apply new evidence to their clinical practice.
• Describe how to address changes to nutrition guidance and individualize guidance in real life settings.

Empowered Eater No. 1: Earl

“My wife calls me the ‘Q King. I’m known for my dry-rub ribs. So the caveman diet sounds good. No bread, potatoes, stuff that’s white.”
• 62yro male, T2D Dx 2017, metformin
• BMI 31 (↑1pt), A1C 9.1, BP 145/90, Chol 204
• No previous MNT, 1-hr. DSMES experience
Earl: Strengths-Based Intel
- Interested in food, flavor, feeding others
- Understands some foods ↑carb
- “Change” talk: caveman diet

Consensus Recommendation
Until evidence surrounding comparative benefits of different eating patterns in specific individuals strengthens, focus on the key factors that are common among the patterns:
- Emphasize nonstarchy vegetables
- Minimize added sugars and refined grains
- Choose whole foods over highly processed foods to the extent possible

Earl: Individualized Guidance
- Emphasize nonstarchy vegetables
  - “Don’t like texture, taste”
  - Veggies can be grilled, seasoned with rubs
- Minimize added sugars and refined grains
  - “Buns, cornbread, and potato salad!”
  - Consider choosing one favorite, less carby sides
- Whole foods over highly processed foods
  - Interested in making own side dishes?
**Consensus Recommendations**

Refer adults T1D and T2D to MNT at Dx and as needed throughout life span and during times of changing health status to achieve treatment goals.

Refer adults w/ diabetes to DSMES, per national standards.

- MNT by RDN yields A1C absolute decrease up to 2% in T2D, up to 1.9% in T1D at 3–6 months.

**Consensus Recommendation**

...there is not an ideal % of calories from carbohydrate, protein, and fat for all people with or at risk for diabetes; therefore, macronutrient distribution should be based on individualized assessment of current eating patterns, preferences, and metabolic goals.

**WWYD?**

Someone brings up wanting to follow a VLC diet, what would you do?

- A. Share all the risks
- B. Offer an alternative, such as diabetes plate method
- C. Assess intake, support by offering individualized goals
- D. Provide handouts/food lists for VLC diet
Consensus Recommendation
A variety of eating patterns (combinations of different foods or food groups) are acceptable for the management of diabetes.

Empowered Eater No. 2: Elaine
“Gastroparesis was a shock. I worried about going blind, not my stomach. I’ve always been a healthy eater. I eat veggies. I carb count. I don’t let myself have sweets.”
- 51yro female, T1D Dx 1982, MDI
- BMI 26, A1C 8, BP 117/74, Chol 160
- Diabetes education decades ago

Elaine: Strengths-Based Intel
- Understands cause-effect of food and BGs
- Skilled in planning, choosing what to eat
- Years-long attention to self-management
Consensus Recommendations
During MNT and DSMES, screen and evaluate for disordered eating; nutrition therapy should accommodate these disorders
Prevalence in diabetes varies, 18–40%
Selection of small-particle-size food may improve symptoms of diabetes-related gastroparesis
Correcting hyperglycemia (slows gastric emptying)
CGM/pump may aid dosing and timing of insulin

Elaine: Individualized Guidance
• Assess for disordered eating
  – “I don’t let myself have sweets”
• Small-particle-size foods
  – “Baby food!”
  – What is acceptable? Cooking vegetables, smoothies
• Address hyperglycemia
• CGM/pump
  – “Shots don’t bother me.”
  – Explore interest in/access to pump/CGM

Empowered Eater No. 3: Euna
“We have 4 beautiful babies—oldest is 17 youngest is 5 going on 50! I want my kids to eat healthy, do well in school. But I can’t make 6 dinners to keep everyone happy. “
• 37yro female, prediabetes Dx 2014
• BMI 34, A1C 6.0, BP 150/94, Chol 200
Euna: Strengths-Based Intel

- Takes family caregiving roles very seriously
- Understands value of modeling healthy eating, education
- Has potential social support system via her family members

Consensus Recommendation

To support weight loss and improve A1C, CVD risk factors, and quality of life in adults with overweight/obesity and prediabetes or diabetes, MNT and DSMES services should include an individualized eating plan in a format that results in an energy deficit in combination with enhanced physical activity.

- 7-10% weight loss (unless additional weight loss is desired for other reasons).

What’s an Individualized Plan?

Individualized eating plans consider:

- Energy deficit
- Dietary preferences
- Health literacy/numeracy
- Resources
- Food availability
- Cooking skills
- Disordered eating
- Sustainability
**Euna: Individualized Guidance**

- Focus on 1–2 goals, created by Euna
  - Eat healthier? Explore quick, convenient options (frozen vegetables)
  - Weight loss? Reduce sat. fat in small ways (helps reduce CVD risk)
  - Move more? Strategies that use available opportunities (walk at work) or provide family time (active play w/ kids)

- 7-10% weight loss is goal, but health of the whole person must always come first

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**WWYD?**

**Ed, T1D, on-target A1C/BP/lipids, BMI 32**

What nutrition counseling may be warranted?

- A. Focus on medication management
- B. Explore weight management plan
- C. Encourage: “keep doing what you’re doing!”
- D. Provide handouts/food lists for low-carb diet